Town of Huntington

Department of Human Services

Office of Handicap Services, Room 205
423 Park Avenue, Huntington, NY 11743
(631) 351-3068 https://www.huntingtonny.gov/snow-berm-removal

Application for Snow Berm Removal Program for Persons with Disabilities with Limited Income

This Program is designed to assist persons with disabilities with *limited income and no other means of removing the snow berm* at the end of their driveway.

ALL APPLICATIONS MUST BE COMPLETE AND ACCOMPANIED BY THE FIRST TWO PAGES OF YOUR TAX RETURN FROM THE PREVIOUS YEAR. IF YOU DO NOT FILE A TAX RETURN, YOU MUST SEND A COPY OF YOUR NON-FILING VERIFICATION FROM THE INTERNAL REVENUE SERVICE (FORM 4506-T). INCOMPLETE APPLICATIONS WILL BE RETURNED.

☐ **First 2 Pages of your prior year Tax Return**
☐ ***Copy of Non-Filing Verification from the IRS***

Name_____**Age**_____

Address_____**Town**_____**Zip**_____

Telephone Number _____ **Cell Number**_____

Email_____ **Disability**_____

Do you rent_____ **or own** _____**your home?**

Do you have any dependents? _____**If yes, how many?** _____

Do you use a mobility aid (i.e.; wheelchair, cane, prosthesis)? ***Circle one*** **YES NO**

If YES, please specify which type_____

If you have a NYS Handicapped Parking Permit or Handicapped Symbol Access License Plate

Please provide the following: Permit #_____ **License Plate #**_____

Do you visit a Doctor, Hospital or Clinic on a Regular Basis? ***Circle one*** **YES NO**

If YES, how often? _____.

Please provide the following: Name, Address and Phone Number of your Physician:

DOCTOR'S NAME: _____

DOCTOR'S ADDRESS : _____

DOCTOR'S PHONE NUMBER: _____

Do you require life-sustaining treatment such as dialysis, use of a respirator or chemotherapy,…?

☐ **Yes** ☐ **NO**

(specify)_____

List all other persons residing at your address

NAME	AGE	REASON THEY CAN'T HELP WITH SNOW REMOVAL

I certify that my *TOTAL GROSS YEARLY HOUSEHOLD INCOME*
(Including all persons residing in the house) is

$_____

I understand that the information provided on this application is to be used for the processing of my Snow Berm Application. I certify that all of the information on this application is true and that all statements are accurate under the penalty of perjury.

I fully authorize the Town of Huntington to verify any and all of the information contained herein.

Signature _____ Date_____

Please return the application to:
Town of Huntington
Department of Human Services
Office of Handicap Services
423 Park Avenue, Room 205
Huntington, NY 11743

You must apply each year for this program.